STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G606	A. BUILDING 01 B. WING	09/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	3025 GREENHILLS LN S INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 09/01/15 Facility Number: 001175 Provider Number: 15G606 AIM Number: 100245640 At this Life Safety Code survey, REM-Indiana, Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story building with a basement was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in corridors, bedrooms and all living areas. The facility has a capacity of 8 and had a census of 6 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A,	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.1. Quality Review completed 09/09/15 -DA.			
K S152 Bldg. 01	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. (2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. (3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. Based on record review and interview,	K S152	All Direct Support Professionals	10/01/2015

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	the facility failed to provide documentation of a fire drill conducted on the first shift and second shift for 4 of 4 quarters and on the third shift for 3 of 4 quarters. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review with the Program Director from 10:30 a.m. to 11:20 a.m. on 09/01/15, documentation of a fire drill conducted on the following shifts and quarters was not available for review: a. on the first shift for the fourth quarter of 2014 and the first, second and third quarters of 2015. b. on the second shift for the fourth quarter of 2014 and the first, second and third quarters of 2015. c. on the third shift for the fourth quarter of 2014 and the second and third quarter of 2015. Based on interview at the time of record review, the Program Coordinator stated fire drill records were recently taken to the corporate office for an Indiana State Department of Health health care surveyor's review and acknowledged documentation of fire drills conducted on the aforementioned shifts and quarters in 2014 and 2015 was not available for review at the facility. In addition, based on telephone interview with the Area		will receive a retraining every other month to ensure that they understand the importance of completing the monthly fire drills. The retraining will include reviewing a copy of the Fire Drill Schedule. The fire drills for this particular group home were found after the completion of the survey. This writer will attach for supporting documentation. Ongoing, the Direct Support Professionals will complete one fire drill per month (or more as needed) according to the schedule to ensure that the health and safety of the client's needs are met. Ongoing, all completed fire drill reports will be turned in to and reviewed by Quality Assurance for accuracy and thoroughness of each drill.	

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	Director at 3:00 p.m. on 09/03/15 documentation of fire drills conducted on the aforementioned shifts and quarters in 2014 and 2015 could not be located and were not available for review.			